



Coronavirus Disease 2019 (COVID-19)

Healthcare Infection Prevention and Control FAQs for COVID-19

Updated May 20, 2020

Page Summary

This page was updated on April 23, 2020 to align with the revised [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).

Who is this for: Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.

What is it for: This creates FAQs to support the existing [Healthcare Infection Prevention and Control Guidance for COVID-19](#).

How is it used: To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Do CDC's interim infection prevention and control recommendations for COVID-19 apply to psychiatric hospitals or other behavioral health facilities?

Yes. To keep patients and healthcare personnel (HCP) healthy and safe, CDC's infection prevention and control guidance applies to all settings where healthcare is delivered. However, as with any guidance, facilities can tailor certain recommendations to their setting. For example, inpatient psychiatric care includes communal experiences and group activities that may need to continue. If so, these activities might need to be adapted to align with [social distancing](#) recommendations. Other recommended infection control measures (for example, ensuring access to alcohol-based hand sanitizer, cohorting patients with COVID-19 and assigning dedicated staff, or implementing universal source control measures) might not be safe or appropriate to implement in all locations or for all patients due to security and behavioral concerns.

Challenges and potential solutions specific to behavioral health settings might include:



- Cohorting
 - **Challenge:** To prevent transmission, it is generally recommended that patients with COVID-19 be transferred to a separate area of the facility where they can be cared for by dedicated HCP. Because of security concerns or specialized care needs, it might not be possible to cohort certain patients together or change HCP assigned to their care.
 - **Potential Solutions:** When cohorting is not possible, implement measures to maintain social distancing (at

least 6 feet) between patients with COVID-19 and others on the unit. Ideally, this would include a separate bathroom for COVID-19 patients. Ensure HCP wear [all recommended personal protective equipment \(PPE\)](#) when caring for patients with suspected or confirmed COVID-19.

- Group Therapy Sessions
 - **Challenge:** Group counseling, therapy, and discussion sessions are a critical component of psychiatric treatment and care plans, but the traditional set-up for these activities is not compatible with social distancing recommendations.
 - **Potential Solutions:** When possible, use virtual methods, or decrease group size so social distancing can be maintained. In the event that COVID-19 is transmitted in the facility, sessions should stop or move to a video discussion forum until additional infection prevention measures are in place to stop the spread.
- Cloth Face Coverings
 - **Challenge:** For some patients, the use of cloth face coverings or facemasks might pose an additional danger or may cause distress. Some patients may be unable or unwilling to use them as intended. Elastic and cloth straps can be used for strangling oneself or others, and metal nasal bridges can be used for self-harm or as a weapon.
 - **Potential Solutions:** Consider allowing patients at low risk for misuse to wear cloth face coverings or facemasks, with a preference for those with short ear-loops rather than longer ties. Consider use of cloth face coverings or facemasks during supervised group activities. Ensure that HCP interacting with patients who cannot wear a cloth face covering or facemask are wearing eye protection and a facemask (or a respirator if the patient is suspected to have COVID-19 and respirators are available).
- Alcohol-based Hand Sanitizer
 - **Challenge:** While alcohol-based hand sanitizer (ABHS) containing 60-95% alcohol is an important tool to increase adherence to [hand hygiene](#) recommendations, ABHS must be used carefully in psychiatric facilities to ensure it is not ingested by patients.
 - **Potential Solutions:** Consider not placing ABHS in patients' rooms in psychiatric facilities, nor in locations where the patients have unsupervised access. Encourage frequent hand washing with soap and water for patients and HCP. Consider providing personal, pocket-sized ABHS dispensers for HCP.
- Dining
 - **Challenge:** As part of social distancing, communal dining is generally not recommended. However, eating needs to remain supervised due to the potential for self-harm with eating utensils and because commonly used psychiatric medications may cause side effects (e.g., tardive dyskinesia, dysphagia, hypo- and hypersalivation) that increase choking risk for patients.
 - **Potential Solutions:** One option is to position staff in patients' rooms to monitor their dining. Another option is to allow communal dining in shifts so that staff can monitor patients while ensuring they remain at least 6 feet apart. A third option is to have patients sit in appropriately spaced chairs in the hallway outside their rooms so they can be monitored while they eat.
- Smoking
 - **Challenge:** A higher proportion of psychiatric patients smoke cigarettes compared to the general population. Patients might congregate in outdoor smoking spaces without practicing appropriate social distancing.
 - **Potential Solutions:** Limit the number of patients allowed to access smoking spaces at the same time, and position staff to observe and ensure patients are practicing appropriate physical distancing.

If a long-term care facility has a resident or staff member with suspected or confirmed COVID-19, how and to whom should this be communicated?

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Facilities should follow the reporting requirements of their state or jurisdiction. Those regulated by the Centers for Medicare and Medicaid Services (CMS) (e.g., nursing homes) should also follow all [CMS requirements](#)  , which are being updated to include new requirements for reporting to CDC and to residents and their representatives.

In addition, [CDC recommends](#) that [health departments](#) be promptly notified about:

- Residents or healthcare personnel (HCP) with suspected or confirmed COVID-19,
- Residents with severe respiratory infection resulting in hospitalization or death, and
- ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

These could signal an outbreak of COVID-19 or other respiratory disease in the facility. The health department can provide important guidance to assist with case finding and halting transmission.

The facility should also have a plan and mechanism to regularly communicate with residents, family members, and HCP, including if cases of COVID-19 are identified in the facility. Often, information in nursing homes is communicated through town hall meetings and staff meetings, along with letters or emails. However, during the COVID-19 pandemic, in-person gatherings should not occur. Instead, communication should occur through virtual meetings over phone or web platforms. These should be supplemented with written communications that provide contact information for a staff member who can respond to questions or concerns. Communications should include information describing the current situation, plans for limiting spread within the facility, and recommended actions they can take to protect themselves and others. Facilities should make this information available in a timely manner and offer periodic updates as the situation develops and more information becomes available.

Is a negative test for SARS-CoV-2, the virus that causes COVID-19, required before a hospitalized patient can be discharged to a nursing home?

No. For patients hospitalized with COVID-19, decisions about discharge from the hospital should be based on their **clinical status** and the ability of the accepting facility to meet their care needs and adhere to recommended infection prevention and control practices. Decisions about hospital discharge are distinct from decisions about [discontinuation of Transmission-Based Precautions](#).

For patients with suspected or confirmed COVID-19, decisions about discontinuing Transmission-Based Precautions should be based on the strategies outlined [here](#). The test-based strategy is **NOT REQUIRED** and might not be possible due to limitations on availability of testing.

If a patient with suspected or confirmed COVID-19 **has not** met criteria for discontinuing Transmission-Based Precautions, they should be transferred to a facility with the ability to adhere to [infection prevention and control recommendations](#) for the care of residents with COVID-19, including placement in a unit or area of the facility designated to care for residents with COVID-19 and provision of recommended personal protective equipment to healthcare personnel.

If the patient with suspected or confirmed COVID-19 **has** met the criteria for discontinuing Transmission-Based Precautions but **has** persistent symptoms (e.g., persistent cough), they should ideally be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline. If the patient **has** met the criteria for discontinuing Transmission-Based Precautions and **does not have** persistent symptoms, they do not require additional restrictions.

A patient hospitalized for non-COVID-related illnesses whose COVID-19 status is not known can be transferred to a nursing home without testing. However, to ensure they are not infected, nursing homes should place them in [Transmission-based Precautions](#) in a separate observation area or in a single-person room until 14 days have elapsed since admission.

As part of [universal source control measures](#), all residents (including those described in the scenarios above) should wear a cloth face covering or facemask (if tolerated) whenever they leave their room.

During the COVID-19 pandemic, are there special considerations for surgical and other procedural care settings, including performance of aerosol-generating procedures (AGPs)?

As part of routine practices, healthcare personnel (HCP) should be applying [Standard Precautions](#). HCP should always deliberately assess potential risks of exposure to infectious material before engaging in activities and procedures in healthcare delivery. Based on their risk assessment, safe work practices, including engineering controls that reduce the release of infectious material, administrative controls, and use of personal protective equipment (PPE) should be implemented at the point of care according to CDC guidelines and standards of practice for the activity performed.

To reduce SARS-CoV-2 exposure during the COVID-19 pandemic, CDC recommends that facilities:

- consider nonoperative approaches when feasible;
- minimize the use of procedures or techniques that might produce infectious aerosols when feasible;
- minimize the number of people in the operating or procedure room to reduce exposures;
- use the [extent of community transmission and an assessment of the likelihood for patient harm if care is delayed](#) to make decisions about cancelling or postponing elective surgeries and procedures; and
- implement universal source control measures, which includes having patients wear a cloth face covering (as tolerated) and having HCP wear a facemask at all times while they are in the healthcare facility.

If surgery or procedures cannot be postponed, HCP caring for patients with suspected or confirmed COVID-19 should adhere to all [recommended infection prevention and control practices for COVID-19](#). This includes:

- Using all recommended PPE: an N95 or higher-level respirator (or facemask if respirators are not available), eye protection, gloves, and a gown.
 - Respirators with exhalation valves should not be used during surgical procedures as unfiltered exhaled breath would compromise the sterile field.
 - If shortages exist, N95 or higher-level respirators should be prioritized for procedures involving higher risk techniques (e.g., that generate potentially infectious aerosols) or that involve anatomic regions where viral loads might be higher (e.g., nose and throat, oropharynx, respiratory tract).
- As part of routine practice, HCP should also be using additional engineering controls for source control, when applicable (e.g., smoke evacuation devices).

Because COVID-19 can be transmitted asymptotically, some infected individuals will not be identified based on clinical signs and symptoms. HCP providing surgical or procedural care to patients not suspected of having COVID-19 should use a tiered approach based on the level of community transmission to inform the need for universal eye protection and respirator use (see FAQ addressing recommended PPE when caring for asymptomatic patients who are not suspected to have COVID-19). HCP should continue to use eye protection or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions.

Why does CDC continue to recommend respiratory protection equivalent or higher to the level provided by an N95 disposable filtering facepiece respirator for care of patients with known or suspected COVID-19?

CDC's guidance to use NIOSH-approved N95 disposable filtering facepiece or higher level respirators when providing care for patients with suspected or known COVID-19 is based on the current understanding of SARS-CoV-2 and related respiratory viruses.

Current data suggest that close-range aerosol transmission by droplet and inhalation, and contact followed by self-delivery to the eyes, nose, or mouth are likely routes of transmission. Long-range aerosol transmission, such as is seen with measles, has not been a feature of SARS-CoV-2.

Potential routes of close-range transmission include splashes and sprays of infectious material onto mucous membranes and inhalation of infectious virions exhaled by an infected person. The relative contribution of each of these is not known for SARS-CoV-2.

Facemasks commonly used during surgical procedures will provide barrier protection against droplet sprays contacting mucous membranes of the nose and mouth, but they are not designed to protect wearers from inhaling small particles. N95 and higher level respirators, such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), and elastomeric respirators, provide both barrier and respiratory protection because of their tight fit and filtration characteristics.

Respirators should be used as part of a respiratory protection program that provides staff with medical evaluations, training, and fit testing.

Although facemasks are routinely used for the care of patients with common viral respiratory infections, N95 or higher level respirators are routinely recommended for emerging pathogens like SARS CoV-2, which have the potential for transmission via small particles, the ability to cause severe infections, and no specific treatments or vaccines.

CDC recommendations acknowledge the current challenges with limited supplies of N95s and other respirators. Facilities that do not have sufficient supplies of N95s and other respirators for all patient care should prioritize their use for activities and procedures that pose high risks of generating infectious aerosols and use facemasks for care that does not involve those activities or procedures. Detailed [strategies for optimizing the supply of N95 respirators](#) are available on the CDC website. Once availability of supplies is reestablished, the guidance states that the use of N95 and higher level respirators should resume.

What personal protective equipment (PPE) should be worn by individuals transporting patients who are confirmed with or under investigation for COVID-19 within a healthcare facility? For example, what PPE should be worn when transporting a patient to radiology for imaging that cannot be performed in the patient room?

In general, transport and movement of the patient outside of their room should be limited to medically essential purposes. If being transported outside of the room, such as to radiology, healthcare personnel (HCP) in the receiving area should be notified in advance of transporting the patient. For transport, the patient should wear a facemask or cloth face covering to contain secretions and be covered with a clean sheet.

If transport personnel must prepare the patient for transport (e.g., transfer them to the wheelchair or gurney), transport personnel should wear [all recommended PPE](#) (gloves, a gown, respiratory protection that is at least as protective as a fit tested NIOSH-certified disposable N95 filtering facepiece respirator or facemask—if a respirator is not available—and eye protection [i.e., goggles or disposable face shield that covers the front and sides of the face]). This recommendation is needed because these interactions typically involve close, often face-to-face, contact with the patient in an enclosed space (e.g., patient room). Once the patient has been transferred to the wheelchair or gurney (and prior to exiting the room), transporters should remove their gown, gloves, and eye protection and perform hand hygiene.

If the patient is wearing a facemask or cloth face covering, no recommendation for PPE is made typically for HCP transporting patients with a respiratory infection from the patient's room to the destination. However, given current limitations in knowledge regarding COVID-19 and following the currently cautious approach for [risk stratification and monitoring of healthcare personnel caring for patients with COVID-19](#), use of a facemask by the transporter is recommended for anything more than brief encounters with COVID-19 patients. Additional PPE should not be required unless there is an anticipated need to provide medical assistance during transport (e.g., helping the patient replace a dislodged facemask).

After arrival at their destination, receiving personnel (e.g., in radiology) and the transporter (if assisting with transfer) should perform hand hygiene and wear [all recommended PPE](#). If still wearing their original respirator or facemask, the transporter should take care to avoid self-contamination when donning the remainder of the recommended PPE. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States.

Interim guidance for EMS personnel transporting patients with confirmed or suspected COVID-19 is [available here](#). EMS personnel should wear all recommended PPE because they are providing direct medical care and in close contact with the patient for longer periods of time.

Given the potential for asymptomatic transmission of SARS-CoV-2, what personal protective equipment (PPE) should be worn by healthcare personnel (HCP) providing care to patients who are not suspected to have COVID-19?

The potential for asymptomatic SARS-CoV-2 transmission underscores the importance of applying prevention practices to all patients, including social distancing, hand hygiene, surface decontamination, and having patients wear a cloth face covering or facemask (for source control) while in a healthcare facility. To protect patients and co-workers, HCP should wear a facemask at all times while they are in a healthcare facility (i.e., practice source control). Use of a facemask, instead of a cloth face covering, is recommended for HCP, because a facemask offers both source control and protection from exposure to splashes and sprays of infectious material from others.

- HCP caring for patients with suspected or confirmed COVID-19 should continue to wear gloves, a gown, respiratory protection that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator (or facemask if respirators are not available), and eye protection (i.e., goggles or disposable face shield that covers the front and sides of the face).
- HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic patients with COVID-19. If COVID-19 is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#) if required based on the suspected diagnosis). They should also:
 - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others.
 - Wear an N95 or higher-level respirator, instead of a facemask, for:
 - Aerosol-generating procedures (See [Which procedures are considered aerosol generating procedures in healthcare settings FAQ](#)) and
 - Surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) (see [Surgical FAQ](#) below).
 - Respirators with exhalation valves are not recommended for source control and should not be used during surgical procedures as unfiltered exhaled breath would compromise the sterile field
- For HCP working in areas with minimal to no community transmission, the universal eye protection and respirator recommendations (described above) for areas with moderate to substantial community transmission are optional. However, HCP should continue to use eye protection or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions. Universal use of a facemask for source control is recommended for HCP.

Depending on testing availability and how rapidly results are available, facilities can also consider implementing pre-admission or pre-procedure testing for COVID-19. Testing results might inform decisions for universal use of eye protection and respirators as described above, especially if there are PPE shortages. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.

Definitions:

- [Substantial community transmission](#): Large scale community transmission, including communal settings (e.g., schools, workplaces)
- Minimal to moderate community transmission: Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases
- No to minimal community transmission: Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting

What personal protective equipment (PPE) should be worn by environmental services (EVS) personnel who clean and disinfect rooms of hospitalized patients with COVID-19?

In general, only essential personnel should enter the room of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient. If this responsibility is assigned to EVS personnel, they should wear all [recommended PPE](#) when in the room. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene.

After discharge, terminal cleaning may be performed by EVS personnel. They should delay entry into the room until a [sufficient time has elapsed](#) for enough air changes to remove potentially infectious particles. We do not yet know how long SARS-CoV-2 remains infectious in the air. Regardless, EVS personnel should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on [clearance rates under differing ventilation conditions is available](#)). After this time has elapsed, EVS personnel may enter the room and should wear a gown and gloves when performing terminal cleaning. A facemask (if not already wearing for source control) and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated or otherwise required based on the selected cleaning products. Shoe covers are not recommended at this time for personnel caring for patients with COVID-19.

Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These aerosol generating procedures (AGPs) potentially put healthcare personnel and others at an increased risk for pathogen exposure and infection.

Development of a comprehensive list of AGPs for healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures.

There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings.

Commonly performed medical procedures that are often considered AGPs, or that create uncontrolled respiratory secretions, include:

- open suctioning of airways
- sputum induction
- cardiopulmonary resuscitation
- endotracheal intubation and extubation
- non-invasive ventilation (e.g., BiPAP, CPAP)
- bronchoscopy
- manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:

- nebulizer administration*
- high flow O2 delivery

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

References related to aerosol generating procedures:

Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE 7(4); <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72.2222> [\[↗\]](#)).

Where should nasopharyngeal swabs be performed on a known or suspected COVID-19 patient, and with what PPE? —

The collection of nasopharyngeal (NP) swabs from patients with known or suspected COVID-19 can be performed in a regular examination room with the door closed. Use of an airborne infection isolation room for nasopharyngeal specimen collection is not required. HCP in the room should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown. If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting NP swabs.

Do all patients with confirmed or suspected COVID-19 need to be placed in airborne infection isolation rooms? —

No. Updated [CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#) recommends placing patients in a regular examination room with the door closed. Airborne infection isolation rooms should be reserved for patients undergoing aerosol generating procedures or for diagnoses such as active tuberculosis.

How long does an examination room need to remain vacant after being occupied by a patient with confirmed or suspected COVID-19? —

Although spread of SARS-CoV-2 is believed to be primarily via respiratory droplets, the contribution of small respirable particles to close proximity transmission is currently uncertain. Airborne transmission from person-to-person over long distances is unlikely.

The amount of time that the air inside an examination room remains potentially infectious is not known and may depend on a number of factors including the size of the room, the number of air changes per hour, how long the patient was in the room, if the patient was coughing or sneezing, and if an aerosol-generating procedure was performed. Facilities will need to consider these factors when deciding when the vacated room can be entered by someone who is not wearing PPE.

For a patient who was not coughing or sneezing, did not undergo an aerosol-generating procedure, and occupied the room for a short period of time (e.g., a few minutes), any risk to HCP and subsequent patients likely dissipates over a matter of minutes. However, for a patient who was coughing and remained in the room for a longer period of time or underwent an aerosol-generating procedure, the risk period is likely longer.

For these higher risk scenarios, it is reasonable to apply a similar time period as that used for pathogens spread by the airborne route (e.g., measles, tuberculosis) and to restrict HCP and patients without PPE from entering the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.

General guidance on [clearance rates under differing ventilation conditions](#) is available.

In addition to ensuring sufficient time for enough air changes to remove potentially infectious particles, HCP should clean and disinfect environmental surfaces and shared equipment before the room is used for another patient.

My hospital is experiencing a shortage of isolation gowns. To preserve our supply, can we stop using gowns for the care of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) and other endemic multidrug-resistant organisms (MDROs), and *Clostridioides difficile*?

CDC has released information about [strategies to optimize the supply of isolation gowns](#). Healthcare facilities should refer to that guidance and implement the recommended strategies to optimize their current supply of gowns. This includes shifting toward the use of washable cloth gowns, if feasible.

The use of gowns as part of Contact Precautions in the context of MDROs has been implemented primarily to reduce the risk of transmission to other patients rather than to protect healthcare personnel (HCP). Facilities with shortages could consider suspending the use of gowns for the care of patients with endemic MDROs, such as MRSA, VRE, and ESBL-producing Gram-negative bacilli except as required for [Standard Precautions](#). Facilities should assess their local epidemiology to determine which MDROs are considered endemic. Regardless of the use of gowns, HCP at facilities should continue to wear gloves for contact with these patients and their environment. Hand hygiene should continue to be emphasized. Facilities should also attempt to place patients colonized or infected with an MDRO in a private room, if available.

- **Caring for patients who have highly resistant Gram-negative organisms (e.g., carbapenem-resistant Enterobacteriaceae) and other MDROs (e.g., *Candida auris*) that are not considered endemic:** Rather than gowns being donned for every room entry, they should be reserved for use as part of [Standard Precautions](#) and also prioritized for high-contact patient care activities that pose highest risk for transfer of pathogens from the patient to HCP. Examples of such high-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care. To further preserve gowns, HCP are recommended to bundle high-contact care activities as part of individual care encounters. Regardless of the use of gowns, HCP at facilities should continue to wear gloves for contact with these patients and their environment. Hand hygiene should continue to be emphasized. Facilities should also attempt to place patients colonized or infected with an MDRO in a private room, if available.
- **Caring for patients with *Clostridioides difficile* infections (CDI):** Facilities should continue using Contact Precautions (putting on a gown and gloves upon entry into the patient's room and placing the patient in a private room) for the care of symptomatic patients with CDI. As part of a [supplemental strategy to prevent transmission of CDI](#), some facilities have implemented Contact Precautions for the care of patients at high risk for CDI who have asymptomatic carriage of *Clostridioides difficile*. There are limited data about the role of asymptomatic carriage in transmission of CDI. In this setting of a critical national shortage of gowns, facilities should consider suspending this approach until the shortage is addressed. Gowns should still be used as part of [Standard Precautions](#).